Final Statement of Reasons

R-3-01

Sections Impacted: Title 10, Sections 2699.100, 2699.200, 2699.201, 2699.202, 2699.205, 2699.206, 2699.207, 2699.210, 2699.300, 2699.301, 2699.303, 2699.304, and 2699.400

Insurance Code Sections 12695, et seq. established the Access for Infants and Mothers (AIM) Program in 1991, to provide health insurance to low and moderate income pregnant women and the infant(s) born during the covered pregnancy. The program, established under the Managed Risk Medical Insurance Board, is funded from three sources; 88% through the Cigarette and Tobacco Products Surtax Fund (Prop. 99), 6% through State General Fund and Federal Funds from Title XXI of the Social Security Act, and 6% through subscriber contributions. AIM is a means tested program, covering pregnant women with family incomes above 200%, but not more than 300% of the federal poverty level (FPL). Women with family incomes below 200% FPL qualify for no cost Medi-Cal services for their pregnancy, which is funded by State and Federal funds. The AIM Program requires a premium, which is 2% of the annual gross family income. In addition, payment of $100 is required for the infant's second year of coverage unless records of up-to-date immunizations are submitted before the baby's 1st birthday in which case, the additional payment is reduced to $50.

Historically, it is estimated that 25% of those women who apply for AIM are eligible for no cost Medi-Cal pregnancy related services. In order to provide greater access to prenatal care, the Board has historically attempted to balance the need for simplicity in eligibility determination, with the need for mirroring Medi-Cal eligibility requirements. The Board has a long term goal of merging the AIM and Healthy Families Program (HFP) eligibility determination functions under one administrative vendor, effective July 2004. The HFP covers children above 100% through 250% of the FPL, so many infants leaving the AIM program at age two will be eligible for HFP. Therefore these regulations also make AIM eligibility determination standards and procedures, and AIM benefit standards, more consistent with the standards in HFP, in order to make these transitions more cost effective and more seamless to AIM applicants and subscribers.

Article 1. Definitions

In order to provide greater consistency and clearer understanding between the AIM Program, HFP, and Medi-Cal, some of the definitions in AIM have been amended. These changes ensure that women and children who might be applying for health coverage through an entitlement program are able to be considered for the Healthy Families and Medi-Cal Programs using the same terms and processes. This ensures a continuum of coverage from 0% of the Federal Poverty Level to 300% of the Federal Poverty Level. The definitions of applicant and family member in particular have been

modified to more closely match and align with the definitions of these terms used by HFP. The MRMIB is revising the definition of "applicant" and adding the definition of "application date" to provide better clarity of who the applicant can be and to provide consistency in regards to specified time frames to complete the application processes. The definitions section is being modified to provide better clarity to the definition of family member and to align the AIM definition of family member(s) with the definition used in the Healthy Families Program regulations. This is to provide consistency between the AIM Program, the HFP Program and the Medi-Cal Program. The definition of federal poverty level has been amended to allow flexibility to adjust to the Federal Poverty Level guidelines that are updated/changed annually.

Many of the changes and additions made to the definitions section are necessary in order to provide guidance in determining eligibility for the Program and to make more consistent to the HFP. The changes in this section are made in accordance with Insurance Code Section 12696 which gives the Board the authority to administer the Program, and 12636.05 which gives the Board authority to determine eligibility standards.

2699.100. Definitions

- Subsection 2699.100(b), definition, "Applicant", is amended to provide better clarity as to who an applicant applying for a pregnant woman can be and to align with the definition of applicant used in the Healthy Families and Medi-Cal for Children Programs.

- A new subsection 2699.100(c), definition, "Application Date", is added to provide a consistent reference point when referring to processing times and due dates for both the Program and the applicant. This change will help to ensure applicants receive health coverage in a timely manner.

- The original subsection 2699.100(c), definition, "Board", is renumbered to subsection 2699.100(d)

- The original subsection 2699.100(d), definition, "Child", is deleted as the term "children under age 21" is incorporated into the definition of "family member" in order to better align with HFP definition of family member and provide consistency with the Medi-Cal Program.

- The original Subsection 2699.100(j), definition, "Family Income", is deleted as "family income" is now modified and incorporated into the definition of "gross household income" in order to better align with the HFP definition and to provide better clarity and consistency with the Medi-Cal Program.

- The original Subsection 2699.100(k), definition, "Family Member", is renumbered to 2699.100(j) as a result of the deletion of the original subsection 2699.100(j) as noted above. In addition, the definition of "family member" in subsection 2699.100(j) is amended to include "children under age 21, of married or unmarried parents, who live in the home or are away at school and claimed as tax dependents" and "unborn child of any family member", to provide better clarity and to align with the HFP definition of family member. These changes clarify who is counted as a family member and make the definition of family member consistent the HFP and Medi-Cal Programs.

    - *Through the Second 15-Day Public Notice process, Subsection 2699.100(j)(5) was revised to clarify that the unborn child being counted as a family member is in reference to the unborn child of the pregnant woman that the application for AIM coverage has been filed and not the unborn child of anyone else living in the household. The change is necessary to provide consistency between the AIM Program and the Medi-Cal for Pregnant Women Program, and to assure there are no gaps between the two programs. The change is made in accordance with Insurance Code Section 12696 which gives the Board the authority to administer the Program, and 12636.05 which gives the Board authority to determine eligibility standards. This change impacts the AIM application. The application will be updated at the next printing to reflect this change in definition and a draft of the change is included with the application (Item 15 in the Rulemaking File Index).*

- Subsections 2699.100(j) through 2699.100(x) were renumbered to reflect the additions and deletions made to the definitions section.

- Subsection 2699.100(k), the definition of Federal Poverty Level, is changed to remove the reference to the annual revision date by referring only to the title, "Poverty Guidelines for the 48 Contiguous States and the District of Columbia, the source, Annual Update of HHS Poverty Guidelines as published in the Federal Register, and the author, the U.S. Department of Health and Human Services. With this change, it will no longer be necessary to update this section every year. The title, source, and author have remained consistent for a number of years. Insurance Code Section 12698(b)(1), establishes the official Federal Poverty Level as income eligibility standard for the Program.

- The definition in Subsection 2699.100(l) is changed from "Gross family income" to "Gross household income". The word "gross" is also added to the definition in referring to the total annual "gross" income of all family members except dependent children. The change is made to distinguish between gross income before appropriate "income deductions" in subsection 2699.100(m).

- Subsection 2699.100(m)(2), definition, “Income Deduction”, is modified to clarify that up to $175 can be deducted for dependent care expenses for a disabled dependent living in the home. The change clarifies that a dependent must be disabled and living in the home to qualify as a dependent care expense deduction. This change is consistent with HFP and Medi-Cal.

- In Subsection 2699.100(m)(4), the words “up to” are deleted from the definition of income deduction for alimony payments received by the pregnant woman. This change is made to align with the HFP regulations for alimony deduction.

Article 2. Eligibility, Application, and Enrollment

The subsections under Eligibility, Application, and Enrollment are being changed and modified in order to provide more clarity and consistency throughout the regulations, as well as to help align the AIM Program with the HFP and Medi-Cal Programs. The term “application date” is replacing other terms previously used such as “at the time of signing” in order to provide a consistent frame of reference when referring to time frames and due dates. The word “individual” in several subsections of the Application Subsection is changed and replaced with “pregnant woman.” This change is made in order to provide added clarity when requesting information on the pregnant woman and to distinguish between the pregnant woman and the applicant who may not be the pregnant woman. Additional changes are made to the subsections regarding income documentation in order to align the AIM Program with the HFP and Medi-Cal Programs. A new subsection 2699.202(b)(2) is added under the Initial Review of Application Section regarding incomplete applications and the process the Program will follow. This addition is intended to provide better customer service. Currently the incomplete application is returned to applicant. Under the new process, the Program will attempt to reach the applicant by phone to inform him or her of the information that is required in order to complete the application. A letter will also be sent to the applicant informing him or her of the information that is required to complete the application and explaining that the application will be retained by the Program until the missing information is received.

These are necessary in order to provide guidance in determining eligibility for the Program and to make AIM more consistent with the HFP. The changes in this section are made in accordance with Insurance Code section 12696.05, which gives the Board the authority to determine eligibility criteria for the Program.

2699.200. Basis of Eligibility

- Subsection 2699.200(b)(1)(A), on certification of pregnancy, is modified to provide better clarity about the individuals who can certify pregnancy for program eligibility. It clarifies that a staff person from Planned Parenthood is authorized to certify pregnancy even if Planned Parenthood staff are not certified

professionals. This change recognizes that this organization uses special classifications not listed in this section for their staff who are qualified to certify pregnancy and who work under the guidance of certified medical professionals. In addition, the term "application date" is added to provide clarity and consistency in measuring time frames.

- Subsection 2699.200(b)(1)(C), on household income which qualifies a pregnant woman for the program, is changed from "annual family" income to "monthly household" income after income deductions in order clarify the method for establishing income eligibility for the program. This change also aligns with the methodology used for HFP and Medi-Cal, including income deductions.

- Subsection 2699.200(b)(1)(F), on excluding applicants who are in Medicare Part A and Part B or Medi-Cal, is modified to include the words "no cost" when referring to Medi-Cal, as persons on no-cost Medi-Cal are ineligible for the Program, whereas, persons above the no-cost Medi-Cal level may be eligible to receive benefits under the Program. The statement is also changed to note "as of the application date" instead of "at the time of signing the application" in order to provide better clarity when referring to the date the application is submitted to the Program.

- Subsection 2699.200(b)(1)(G), on excluding applicants with maternity benefits in a private insurance arrangement, is changed to reference "application date," instead of "at the time of signing of the application" in order to provide consistency when referring to time frames/due dates. The word individual is changed to pregnant woman in order to provide clarity.

2699.201. Application

- Subsection 2699.201(a)(3), on a signed statement agreeing to pay full subscriber contributions if the pregnant woman is enrolled, is changed to provide clarity that the applicant may be the pregnant woman or someone applying on her behalf. The statement is modified to be consistent with the new definition in section 2699.100.

- Subsection 2699.201(b), on signing a declaration stating that the application information is true and accurate, is changed, replacing the phrase "individual or the individual's parent, conservator, or guardian" with "applicant". In addition, "to the best of his or her knowledge" is added to the end of the statement. This change is intended to provide integrity to the program and to clarify the applicant's reason for providing a signature.

- Subsection 2699.201(c), on returning an incomplete application, is modified to change the process that the applicant will be notified in writing that the

application is incomplete and of the documentation that is required for completion. The change is done to provide better service to the applicant and to insure the eligibility determination can be completed more timely.

The introductory paragraph to Section 2699.201, which lists the components of the AIM application, has been updated to reflect the current July 2002 edition date of the AIM application.

- Subsection 2699.201 (d)(1)(A-E), which lists the application components, is modified to change the word "individual" to "pregnant woman." This change provides clarification that the information requested is for the pregnant woman and not the applicant, who may not be the person applying for benefits.

- Subsection 2699.201(d)(1)(F), on pregnancy certifications, is modified to conform with changes made in subsection 2699.200(b)(1)(A).

- Subsection 2699.201(d)(1)(G), requesting first day of the last menstrual period, is modified to change the word "individual" to "pregnant woman."

- Subsection 2699.201(d)(1)(H) was added on to provide more clarity to the declaration that the pregnant woman is not beyond 30 weeks gestation. This change also aligns with section 2699.100(c), which states the application date is the date the application is sent to the program. The word "individual" is changed to "pregnant woman". The word "her" is changed to "applicant's." The word changes are made to provide clarity and consistency, noting that the applicant may or may not be the pregnant woman and clarifying that the information requested on the application is in reference to the pregnant woman.

- Subsection 2699.201(d)(1)(K), on listing the family members living in the home, is modified to change the words "individual making application" to "pregnant woman" to clarify what the relationships of other persons in the household are to the pregnant woman rather than to the applicant, who may not be the person requesting benefits.

- Subsection 2699.201(d)(1)(M), on income documentation, is reworded from "the individual's total annual gross family income," to request the "total monthly gross household income". The statement is also amended to include a request to provide documentation for each source of income. The change is made to provide consistency with the amended definition of "monthly household income," which is used to determine program eligibility in subsection 2699.200(b)(1)(c) and to align with the HFP.

- Subsection 2699.201(d)(1)(M)1.a. is added to the list of income documentation options, to include a Federal Income Tax Return with Schedule C as acceptable documentation of income for the previous calendar year for household members who are self employed. This change also aligns with the HFP and no cost MC Programs.

- Subsection 2699.201(d)(1)(M)1.a. is renumbered and is now Subsection 2699.201(d)(1)(M)1.b. The statement is also revised to clarify that the 1099 Interest (INT) form instead of "all 1099 forms" are acceptable income documentation. This statement is closed with "and/or" instead of a "period" to note that there are other acceptable ways to document monthly gross household income for a previous calendar year. The changes are made in order to provide alternatives for persons other than self employed, to submit tax and income related documentation for those that may not have filed a current year Federal Tax Return.

- Subsection 2699.201(d)(1)(M)2.a.i., on using a letter from a person's current employer to verify income, is amended to note that the letter must be dated. This change allows the program a consistent manner to ensure that income verification for the current year is for a period within the last 45 days. This change makes this type of income verification consistent with other current calendar year verification and aligns with the HFP and Medi-Cal Programs income verification requirements.

- Subsection 2699.201(d)(1)(M)2.a.i.(ii), requiring the employer's Federal Tax Identification Number, is deleted as the employer's Federal Tax ID number is not relevant to the statement about the employee's earned income.

- Subsection 2699.201(d)(1)(M)2.a.i.(iii-vii) are renumbered due to the deletion of the previous subsection 2699.201(d)(1)(M)2.a.i.(ii).

- Subsection 2699.201(d)(1)(M)2.a.i.(iii)., on a statement of a person's current gross monthly income, is changed from "on an annualized basis" to request a statement of "the person's current gross monthly income" for a period ending within 45 days of the application date. The change is made to align with the HFP and no-cost Medi-Cal Programs.

- Subsection 2699.201(d)(1)(M)2.a.i.(vi) is modified so that the word "paycheck" is changed to "pay stub" since the pay stub is the document which provides the most information about the gross income received, before deductions, which is the amount on a pay check.

- Subsection 2699.201(d)(1)(M)2.a.ii. is changed to request a pay stub instead of a pay check and also is revised to clarify that pay or unemployment check stubs

are to show gross income for a period ending within 45 days of the application date instead of "for a period ending within 35 days" from the time of the application. This change is made to align with the HFP and to be consistent in terms of the time frames/due dates required taking into account the addition of the definition of application date in subsection 2699.100(c).

- Subsection 2699.201(d)(1)(M)2.a.iii., on submitting self employment profit and loss statement as income documentation, is amended to clarify that a self employment profit and loss statement must be for the most recent three month period of the time of the application date. This change, in conjunction with the new definition of application date, is to ensure a better understanding by the applicant of what is the acceptable income verification for persons using a profit and loss statement.

- Subsection 2699.201(d)(1)(N), on documentation of court ordered child support, is revised and restated to match the HFP requirement regarding documentation of child support, alimony, or dependent care expenses paid by each family member living in the home. Subsections 2699.201(d)(1)(N)1. and 2. are deleted as they are incorporated into the revision. The change is made to clarify allowable deductions which are necessary to determine income eligibility for the Program.

- Subsection 2699.201(d)(1)(O), the declaration that the individual is not on Medi-Cal or Medicare Part A and Part B, is modified to change the word "individual" to "pregnant woman" for consistency and "no-cost" is added to Medi-Cal for clarification, since women in the "share of cost" Medi-Cal Program may be eligible for the Program.

- Subsection 2699.201(d)(1)(P)., the declaration on residency, is modified to change the word "individual" to "pregnant woman" to clarify that the pregnant woman receiving the health coverage must be a resident of the state of California.

- Subsection 2699.201(d)(1)(Q), the declaration that the applicant will abide by the program rules and processes, is modified to change the word "individual" to "applicant" in the first part of the statement and the word "individual" is changed to "pregnant woman" in the second part of the statement. The change is made to be consistent with the other word changes made in these regulations.

- Subsection 2699.201(d)(1)(R), the declaration about other health insurance coverage, is modified to change the word "individual" to "pregnant woman," and the statement is also amended to request the additional information of the name, address, and policy number of any current insurance or health plan that is in effect for the pregnant woman. This change ensures that the other health

coverage information requested is for the pregnant woman applying for benefits and not the applicant who may not be the same person. This change is made to help ensure there is adequate information provided regarding other health insurance coverage so as to be able to coordinate benefits between the Program and the other health insurance coverage.

- Subsection 2699.201(d)(1)(S), the declaration about other maternity benefits, is modified to change the word "individual" is changed to "pregnant woman" in the first part of the first sentence. The word individual is changed to "applicant" in the second part of the first sentence and the word individual is changed to "pregnant woman" in the second sentence of the statement. The words are changed to provide clarity and to distinguish between the pregnant woman and the applicant as the applicant, who may or may not be the pregnant woman.

- Subsection 2699.201(d)(1)(U), requesting information on coverage for others in the family household, is rephrased to request information about the health coverage available to the applicant, spouse or father of the baby in the household, instead of requesting information available to the employees of the primary employer of any parent or spouse who is a family member. The statement is rephrased to be consistent with the revised definition of family member in subsection 2699.100(j). This change is necessary to coordinate coverage with private insurance in the event the infant is covered after birth or the pregnant woman has coverage for services other than maternity.

- Subsections 2699.201(d)(1)(V-X), containing the declarations, is modified to change the word "individual" to "applicant". The change is made to provide consistency and for clarity. The applicant may or may not be the pregnant woman.

- Subsection 2699.201(d)(1)(Z), on indicating a choice of health plan, is modified to change the word "individual" to "pregnant woman". This change clarifies the pregnant woman's health plan selection.

- Subsection 2699.201(d)(1)(BB), is added to include a declaration that the information and documentation is submitted is true and correct. This change assures Program integrity and provides the applicant a better understanding for the reasons to provide a signature.

- Subsection 2699.201(d)(3), is added to allow an applicant to authorize the Program in writing, to forward the application to no-cost Medi-Cal for an eligibility review if the individual is ineligible for the Program. This change ensures that the application of a pregnant woman, who may be below the Program income guidelines, can be forwarded to the no-cost Medi-Cal Program. The goal is to

lower the number of unsponsored births and to assure there are no gaps between the AIM and Medi-Cal Programs.

2699.202. Initial Review of Application

- Subsection 2699.202(b)(1), on an application that is not complete, is revised to reflect the process that will be followed if an application is not complete. This process notes that instead of returning the incomplete application, phone calls will be made to request the missing information and a letter will be sent if the applicant is not reached by telephone. The change is made to provide better service to the applicants by improving the process to complete an application in a more timely manner. This change also aligns to the process followed by HFP for incomplete applications.

- Subsection 2699.202(b)(2) is added to clarify the process that is followed when the documentation to complete an incomplete application is not received within the specified time frame. This is in follow-up to the changes made in subsection 2699.201(b)(1). The specified time frame of 17 days is the time frame an applicant has to submit the necessary documentation required to complete the application, upon the subscriber being notified by the Program, by telephone or in writing, of the missing or incomplete documentation. This change provides a consistent and reasonable standard for the timely processing and/or disposition of an application received by the program.

- Subsection originally numbered 2699.202(b)(2), on a complete application, is renumbered to subsection 2699.202(b)(3) because of the addition of the new subsection 2699.201(b)(1).

2699.205. Registration of Infant

- Subsection 2699.205(b), on notification to the subscriber within 30 days prior to the infant's first birthday, is revised to require the subscriber to notify the program in writing if the subscriber wishes to disenroll the infant from the program. This change is made to provide the subscriber the opportunity to disenroll the infant at the end of the first year if the infant no longer needs insurance. This process will eliminate the subscriber's being billed automatically for a second year of coverage for the infant if the subscriber chooses to disenroll the infant prior to the infant's first birthday.

2699.206. Change of Address

- The title of subsection 2699.206, on change of address, is changed to read "Change of Address and/or Phone Number." Subsection 2699.206 is revised to note that an applicant shall notify the program in writing within thirty days of any

changes in address or phone number. The statement is revised for clarity and to align the process that is followed by the HFP subscribers, and to assure that the mother and baby will be covered by an available health plan at the new address.

2699.207. Disenrollment

- Subsection 2699.207(a)(1), on a subscriber's request for disenrollment, is modified to add the words "In writing." This change ensures that requests for disenrollment from the program are in writing from the subscriber and will ensure that there is documentation of the subscriber's request for disenrollment.

- Subsection 2699.207(a)(2)(C), on the rules regarding a subscriber who is no longer pregnant, is modified to require documentation of miscarriage if the subscriber notifies the program after the effective date that she is no longer pregnant. This change provides a way to verify that the woman is no longer pregnant at the time of her effective date in order to reimburse any portion of the subscriber contributions, as specified in subsection 2699.400(e).

- Subsection 2699.207(b), on transfer effective date, is modified to note that the subscriber will be notified of the effective date of disenrollment of the subscriber and/or infant from the program. The addition of the words "the effective date" provides clarity and more complete information about disenrollment to the subscriber.

- Subsection 2699.207(c), on the effective date of transfer, is modified in order to provide better clarity of when the effective date of a disenrollment would take effect. The change is also being made to align the process of determining the effective date of disenrollment with the process that is followed by HFP. This change better aligns the effective date of disenrollment from the program with the health plan contract provision that coverage ends on the last day of a month.

2699.210. Transfer of Enrollment

- Subsection 2699.210(b), on the effective date of transfer, is reworded to clarify the effective date of a transfer request received by the program for subscribers and/or infants. The change in this subsection provides a more consistent standard for the processing of transfer requests.

- Subsection 2699.210(b)(1), on the effective date of transfer for an infant, is changed from "within 31 days of the approval of the transfer" to the first day of the next month if the request for transfer is received by the 10th of the month, or to the first day of the second month if the transfer request is received after the 10th of the month. This change is made to provide clarity on when the effective

date would be for transfer requests for an infant and to align with the transfer requirements of a child in HFP.

- Subsection 2699.210(b)(2), on the effective date of transfer for the subscriber, is changed from within 31 days of the approval of the transfer to within 17 days of the request for transfer. The time frame of 17 days is shorter than the time frame for an infant to ensure the pregnant woman has access to prenatal services as soon as possible. This time frame allows the Program 7 days to process all such subscriber requests and 10 days for the health plan to be notified in accordance with their contract.

- Subsections 2699.210(c)(1) and (2), on the effective date of transfer, are added in order to be consistent with and provide clarity concerning the rewording in subsection 2699.210(b).

- Subsection 2699.210(d), on the effective date of transfer when the participating health plan in which the subscriber is enrolled is canceled or not renewed, is modified for clarity and for consistency with the other changes in this section.

Article 3. Scope of Benefits

Insurance Code Section 12698.30 requires that the benefits provided in AIM include, at a minimum, those required pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations (CFR). Article 3 is changed to make explicit that participating health plans are required to provide benefits consistent with the Knox-Keene Health Care Service Plan Act of 1975, including its amendments (Health and Safety Code Sections 1367-1374.16) and to align specific benefit descriptions with Knox-Keene requirements. The benefits required by Knox-Keene, although organized and delineated differently than CFR requirements, are fully consistent with the CFR standard. Article 3 is also changed so that, to the extent possible, the AIM Scope of Benefits is consistent with the benefits provided in the Healthy Families Program (HFP). Aligning the AIM and HFP benefits will result in ease of administration for both programs since most infants in the AIM program are eligible to join the HFP once they turn age two, and the current selection process for AIM health plans requires that the plans also participate in HFP. Aligning the benefits will assure continuity of services when an infant transitions from AIM to HFP.

Section 2699.300. Minimum Scope of Benefits

- Subsection 2699.300(a), Basic Scope of Benefits, is amended to require explicitly that participating plans offer health benefits that comply with the Knox-Keene Health Care Service Plan Act of 1975, including its amendments, and applicable regulations. The requirements of the Act are contained in Sections

1367-1374.16 of the Health and Safety Code and in the California Code of Regulations Title 28 Division 1 Chapter 2.

- Subsection 2699.300(a)(1), the requirement for health plans to offer a benefit package pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations is deleted. Adopting the Knox-Keene standard assures consistency with the standard that health plans participating in the AIM Program must comply with to meet licensing requirements.

- Subsections 2699.300(a)(1)(A) and (B) are added to specify the inpatient and outpatient hospital services that are required for the program. These benefits are consistent with the Knox-Keene Health Care Service Plan Act of 1975, including its amendments, and applicable regulations and California Code of Regulations, Title 28 Section 1300.67(b) and (c), and with the benefits offered through the HFP.

- Subsection 2699.300(a)(2), is amended to define durable medical equipment benefits in a manner consistent with Health and Safety Code Sections 1374.51, 1367.6, 1367.63, and 1367.635 and with the benefits offered through the HFP.

- Former Subsection 2699.300(a)(3) is removed. Mental health benefits are moved to Subsection 2699.300(a)(21).

- Former Subsection 2699.300(a)(4) is renumbered subsection 2699.300(a)(3) and is revised to describe medical transportation services. The description of medical transportation services is written to be consistent with Health and Safety Code Sections 1345 and 1371.5, and with the benefits offered through the HFP.

    - *Through the 15-Day Public Notice process, renumbered subsection 2699.300(a)(3) was revised to remove the duplicated sentences in subsection 2699.300(a)(3), on Medical Transportation Services.*

- A new Subsection 2699.300(a)(4) is added to specify that emergency health care services are a covered benefit. The description of emergency health care services is written to be consistent with Health and Safety Code Section 1371.5 and with the benefits offered through the HFP.

    - *Through the 15-Day Public Notice process, subsection 2699.300(a)(4), on Emergency Health Care Services, was revised to be more consistent with Health and Safety Code section 1371.05 and with the benefits offered through the HFP.*

- Former Subsection 2699.300(a)(5), physical, occupational and speech therapy benefits, is moved to new Subsection 2699.300(a)(15).

- New Subsection 2699.300(a)(5) is added to outline professional services provided in the program These services are consistent with California Code of Regulations, Title 28 Section 1300.67(a), 1300.67(a)(1), and 1300.67(f) and with the benefits offered through the HFP.

  Subsection 2699.300(a)(5)(A) is added to specify that eye examinations are a covered benefit.

  Subsection 2699.300(a)(5)(B) is added to specify that hearing tests are a covered benefit.

  Subsection 2699.300(a)(5)(C) is added to specify that immunizations for subscribers and infants are a covered benefit.

  Subsection 2699.300(a)(5)(D) is added to clarify periodic health examinations for subscribers and infants are a covered benefit.

  - *Through the 15-Day Public Notice process, subsection 2699.300(a)(5)(D) was revised to remove the prostrate cancer language on periodic health examinations for subscribers because this screening is not applicable to females who are the only subscribers of the AIM program, or to infants.*

  Subsection 2699.300(a)(5)(E) is added to specify that well baby care is a covered benefit.

- Subsection 2699.300(a)(6) is amended to specify the type of health education services that are covered by the program. This Subsection has been changed to include the type of health education information and recommendations for optimal use of health care services that must be included. This has been added to make this benefit more consistent with the HFP. In addition, this Subsection is amended to include tobacco use prevention and education services which reflect the standard for tobacco use prevention as established for AIM.

- The format of Subsection 2699.300(a)(7) is revised.

- Subsection 2699.300(a)(8), is amended to specify the prescription drug benefits and the smoking cessation exclusion to make this Subsection consistent with Health and Safety Code Section 1367.51

- Subsection 2699.300(a)(9), is revised so that reconstructive surgery benefits are more consistent with Health and Safety Code Sections 1367.6, 1367.63, and 1367.365 and with the benefits offered through the HFP.

- Subsection 2699.300(a)(10) is revised to better describe covered transplant benefits. The standard is set by the Board pursuant to Insurance Code 12695.05 and industry standards.

- Subsection 2699.300(a)(11) is added to specify maternity care benefits that are covered. These benefits are consistent with Health and Safety Code Section 1367.54 and with the benefits offered through the HFP.

- Subsection 2699.300(a)(12)is added to specify the family planning benefits that are covered. These benefits are consistent with California Code of Regulations, Title 28, Section 1300.67(f)(2) and with the benefits offered through the HFP.

- Subsection 2699.300(a)(13) is added to specify diagnostic x-ray and laboratory services that are covered. These benefits are consistent with California Code of Regulations, Title 28 Sections 1300.67(b) and (d) and with the benefits offered through the HFP.

- Subsection 2699.300(a)(14) is added to specify home health services that are covered. The exclusion is added to be consistent with Subsection 2699.301(a)(3), exclusion of custodial care. These benefits are consistent with California Code of Regulations Title 28 Section 1300.67(e) and with the benefits offered through the HFP.

    - *Through the 15-Day Public Notice process, subsection 2699.300(a)(14) was revised to remove the word "short-term" so that home health services and exclusions are more consistent with California Code of Regulations, Title 28, section 1300.67(c).*

- Subsection 2699.300(a)(15) is added to specify that physical, occupational and speech therapy benefits are covered benefits. These benefits are consistent with California Code of Regulations Title 28 Section 1300.67(c) and with the benefits offered through the HFP.

- Subsection 2699.300(a)(16) is added to specify that blood and blood products benefits are covered benefits. These benefits are consistent with California Code of Regulations, Title 28 Section 1300.67(b) and with the benefits offered through the HFP.

- Subsection 2699.300(a)(17) is added to specify that spectacles and lenses are covered benefits when provided in conjunction with a covered cataract surgery. The standard is set by the Board pursuant to Insurance Code 12695.05 and industry standards.

- Subsection 2699.300(a)(18) is added to specify that skilled nursing care services are covered benefits. These benefits are consistent with California Code of Regulations Title 28 Section 1300.67(c) and with the benefits offered through the HFP.

- Subsection 2699.300(a)(19) is added to specify that hospice benefits are covered benefits. These benefits are consistent with Health and Safety Code Section 1368.2 and with the benefits offered through the HFP.

    - *Through the 15-Day Public Notice process, subsection 2699.300(a)(19), on the hospice benefit, was revised to be more consistent with Health and Safety Code section 1368.2 and with the benefits offered through the HFP. Subsection 2699.300(a)(19) is revised to change the limit from 6 to 12 months. This change allows for the hospice benefit to be available when life expectancy is 12 months or less.*

- Subsection 2699.300(a)(20) is added to specify that orthotics and prosthetics benefits are covered benefits. These benefits are consistent with Health and Safety Code Sections 1367.18, 1367.6, 1367.63, and 1367.635. The exclusion is added and set by the Board pursuant to Insurance Code 12695.05 and industry standards.

- Subsection 2699.300(a)(21)(A) and (B) is added to describe mental health benefits and exclusions. These benefits and exclusions are consistent with Health and Safety Code Section 1374.72 and with the benefits offered through the HFP.

    - *Through the 15-Day Public Notice process, subsection 2699.300(a)(2)(B) was revised to remove the exclusion for mental disorders that do not respond to generally accepted methods of treatment for mental disorders such as organic mental disorders with permanent brain dysfunction contained within, be consistent with the benefits offered through the HFP.*

- Subsection 2699.300(a)(22) is added to specify alcohol and substance abuse benefits are covered benefits. These benefits are consistent with Health and Safety Code Section 1367.2.

- Subsection 2699.300(c), reimbursement of nurse practitioners or other advanced practice nurses, is deleted because these services are covered benefits in Subsection 2699.300(a)(5), professional services.

Section 2699.301. Excluded Benefits

- Subsection 2699.301(a)(6) is revised for clarity.

- Subsection 2699.301(a)(9), sex change and reversal of sterilization exclusions, are removed to be consistent with exclusions in the HFP and because the reference to these services is unnecessary. Sex change and reversal of sterilization services would not be required by subscribers in the AIM Program during their prenatal and 60-day post-partum periods.

- Subsection 2699.3001(a)(10) is renumbered Subsection 2699.301(a)(9) and is amended so that the exclusion for eyeglasses is consistent with Subsection 2699.300(a)(17), which provides eyeglasses when medically necessary following a cataract surgery.

- Subsection 2699.301(a)(11) is renumbered Subsection 2699.301(a)(10) and is amended so that the exclusion for long-term care benefits is consistent with Subsections 2699.300(a)(18), skilled nursing, and Subsection 2699.300(a) (19), hospice care.

- Subsection 269.301(a)(12) is renumbered Subsection 2699.301(a)(11) is amended so that the exclusion for dental services are consistent with Health and Safety Code Section 1367.68.

- Former Subsection 2699.301(a)(13), residential treatment of chemical dependency exclusion, is removed to make the chemical dependency benefit consistent with the HFP.

- Former Subsection 2699.301(a)(14), the treatment of obesity by surgical means exclusion, is removed. This exclusion conflicts with the requirement that health plans provide basic health care services (e.g., inpatient professional services, etc.) when medically necessary (California Code of Regulations Title 28 Section 1300.67).

- Subsection 2699.301(a)(15) is renumbered Subsection 2699.301(a)(12) and is amended to clarify the exclusion for cosmetic surgery and to be consistent with Subsection 2699.300(a)(9), reconstructive surgery.

- New Subsection 2699.301(a)(13) is added for clarification to exclude any services or items excluded in Section 2699.300.

- New Subsection 2699.301(a)(14) is added for clarification to exclude any benefit in excess of limits specified in Section 2699.300.

- New Subsection 2699.301(a)(15) is added to specify a limited exclusion of medical conditions resulting from acts of war. This exclusion applies only to instances when a plan is unable to provide health care services because of acts of war. This exclusion is also consistent with Insurance Code Section 12693.615 which prohibits the exclusion of pre-existing conditions in the program.

  - *Subsection 2699.301(a)(15), the acts of war exclusion, was revised to be more consistent with California Code of Regulations, title 28, section 1300.67.05.*

    Through the 15-Day Public Notice process, MRMIB amended the acts of war exclusion (subsection 2699.301(a)(15)) to be consistent with the Department of Managed Health Care's (DMHC) emergency regulations. The DMHC emergency regulation clarified that the acts of war exclusion only applied if the exclusion was approved by specific order of the DMHC director.

    DMHC has now adopted final regulations that forbid the acts of war exclusion in its entirety for health plans it regulates, and no longer permits a specific order by the DMHC director to authorize the exclusion. Therefore, to further track the final DMHC regulations, MRMIB revised this subsection during a third 15-Day Public Notice process to remove the exclusion.

- Subsection 2699.301(a)(16) is added to specify the exclusion for infertility treatment. This is consistent with the scope of benefits in the HFP. Furthermore, infertility treatment is unnecessary because this service is not required for subscribers during their prenatal and 60-day postpartum coverage nor for their infants.

- Subsection 2699.301(a)(17) is added to exclude treatment of an injury or sickness for which such benefits are provided or payable by Worker's Compensation. It is appropriate to exclude benefits provided through Worker's Compensation to avoid the cost of duplicating coverage through AIM.

- Subsection 2699.301(a)(18) is added to exclude services which are eligible for reimbursement by insurance or covered by any other insurance or health care plan. It is appropriate to exclude benefits provided through other insurance to avoid the cost of duplicating coverage through AIM.

2699.303. Services Received Prior to Enrollment

- Subsection 2699.303(a) covers payment for services received prior to enrollment. The words "per subscriber" are deleted and the statement is modified to clarify the time frames stated as (40) calendar days. The word "application" is inserted in front of date to provide clarity and consistency when referring to time frames, for payment.

- In Subsection 2699.303(b), regarding requests for payment, the word "calendar" is added for clarity.

- A technical clarification is made to subsection 2699.303(b)(1) by adding the word "the" to the services being billed.

- A technical change is made to subsection 2699.303(b)(3) to capitalize the "D" in date

- A technical change is made to subsection 2699.303(b)(4) to capitalize the "T" in type.

2699.304 Order of Benefit Determination

- Subsection 2699.304 is better defined by adding "except Medi-Cal" to the statement, noting that AIM would not pay secondary if subscriber had Medi-Cal coverage.

Article 4. Subscriber Contributions

The subsections of section 2699.400 have been modified to provide consistency when referring to a subscriber's household, current immunization standards, and to align with the HFP and current law to note that a federally recognized California Indian Tribal Government can make required subscriber contributions on behalf of a member of the tribe. A new subsection is also added to the subscriber contribution subsection to clarify the process the program follows in regard to subscribers who are in arrears on subscriber contributions. This change helps to ensure that the subscriber is properly notified when he or she fails to fulfill his or her financial commitment to the Program.

The changes made in this section are in accordance with Insurance Code section 12696.05(d), which gives the Board the authority to determine subscriber contributions.

2699.400. Subscriber Contributions

- Subsection 2699.400(a)(2), on the subscriber's cost for participation in the Program, is amended to be consistent with changes made in subsections 2699.100(l) & (m), which define household income and deductions, respectively. A grammatical change is made by changing "in the application" to "with the application".

- Subsection 2699.400(3)(B), on providing documentation on first year vaccinations in order to get a $50 discount on the second year fee for an enrolled infant, is changed from listing the specific immunizations an infant must receive in order to receive the discount to referencing the standards of the Advisory Committee on Immunization Practices, an organization which establishes recognized immunization standards. The change is made to be consistent with changes made to Subsection 2699.300(a)(1)(5)(C), which refers to the Advisory Committee on Immunizations Practices. This change provides flexibility for the program to meet those changing standards.

- Subsection 2699.400(f), on subscriber contributions made on behalf of a member of the tribe, is added in accordance with Chapter 701 Statutes of 2000, which amended Insurance Code Section 12698(c). This establishes that a federally recognized California Indian Tribal Government can make required subscriber and infant contributions on behalf of a member of the tribe.

- Subsection 2699.400(g), on applicants who are in arrears in payment of subscriber contributions, is added to describe the process for notifying the applicant in writing when he or she is over 90 days delinquent in making a subscriber contribution. This change is made to ensure the applicant is informed that his or her account is 90 days past due and will be referred to a credit reporting agency. The change provides the subscriber an opportunity to prevent such action being taken by bringing subscriber contributions current. Insurance Code Section 12698.15 authorizes the Board to use collection services to collect unpaid subscriber contributions.

COMMENTS AND RESPONSES

COMMENTER 1: **Lynn Kersey, Maternal and Child Health Access (MCHA); Lucy Quacinella, Maternal and Child Health Access (MCHA); Manjusha Kulkarni, National Health Law Program**

Comment 1-A: In regards to subsection 2699.200(b)(1)(A), commenter noted that AIM should allow self-verification of pregnancy. Commenter noted that Medi-Cal 200% program allows women to self declare pregnancy and recommended that the AIM program align with this rule.

Response 1-A: The Medi-Cal program for pregnant women provides pregnancy related services only, whereas, the AIM program provides comprehensive medical services. As such, it would it put the AIM contracted health plans at risk to enroll an individual before verifying pregnancy. In addition, the pregnancy certification also provides a benchmark for establishing the estimated date of delivery and verifying the pregnant woman is less than 30 weeks pregnant.

Comment 1-B: Commenter requests the AIM Program to stop excluding women who are beyond the 30th-week of pregnancy, as still required in Section 2699.201(b)(1)(A), noting that this exclusion adds to the unnecessary confusion and complication about eligibility rules in the state's programs for pregnant women.

Response 1-B: The intent of the AIM Program is to both decrease the number of uninsured births and to improve birth outcomes. This is best accomplished through early prenatal care. Therefore, the 30 week requirement has been established in the regulations. This is also a contractual issue with the health plans participating in the AIM Program. To include higher risk women (over 30 weeks gestation) may further reduce the number of providers and plans who are willing to participate in the AIM Program and limit overall program access. This is also contrary to the intent of the AIM Program which is intended to provide comprehensive early prenatal care to women.

Comment 1-C: Regarding subsection 2699.400(a)(2), the commenter recommends that AIM stop requiring that women whose pregnancies have ended, including those who miscarry, to pay in full as if they were pregnant, or face collection action. Commenter requests that the

existing regulation requiring women to pay for 12 months, even when AIM coverage lasts many fewer months, be amended.

Response 1-C: The 12 months is a payment plan and is not tied to insurance coverage. This rate includes all services available to and received by the enrolled subscriber. The State's payment method to health plans is to pay a risk payment which covers all levels of risk, including early miscarriage, normal delivery, or an expensive neonatal intensive care delivery. Because of the risk payment method, the payment to the health plan is not reduced if there is a miscarriage. Both the State and the AIM family are therefore sharing in the cost of this risk payment. As such, women applying to AIM acknowledge the requirement to pay the full 2% when initialing declaration #10 on the AIM application. In an effort to ease the financial responsibility requirement, the AIM Program allows subscribers to establish a 12 month payment plan. Subscribers also have the option of paying the full 2% at the time of application, and receive a discount when they do.

Section 12698.15, of the Insurance Code, prohibits disenrollment from the AIM Program for non-payment and instead allows collection actions as the alternative. The collection method used by the AIM Program is to report delinquent accounts to a credit bureau as opposed to other collection alternatives.

Comment 1-D: The commenter recommends that a regulation be adopted that would require AIM subscribers be informed of the option to switch to Medi-Cal if income drops below 200% during pregnancy.

Response 1-D: This recommendation has not been incorporated because it is being proposed as an additional regulation for an issue not part of this regulation filing.

Comment 1-E: The commenter recommends that the proposed regulation on credit reporting be rejected.

Response 1-E: Subsection 2699.400(g), regarding applicants who are in arrears in payment of subscriber contributions, was added to describe the process for notifying the applicant in writing when he or she is over 90 days delinquent in making a subscriber contribution. The AIM handbook states that if the subscriber does not pay their total cost on time, reminder notices will be sent and the applicant will be reported to a credit reporting agency. The change in the regulations is made to ensure the applicant is informed that his or

her account is 90 days past due and will be referred to a credit reporting agency. The change provides the subscriber an opportunity to prevent such action being taken by bringing subscriber contributions current. Insurance Code Section 12698.15 authorizes the Board to use collection services to collect unpaid subscriber contributions.

Comment 1-F: AIM should allow subscriber contributions to be paid by the same entities that are allowed to pay for Healthy Families subscribers under the sponsorship provisions for HFP.

Response 1-F: Subsections 2699.200(b)(1)(E), 2699.201(d)(1)(Y) and 2699.400(d), regarding limitations on payment of subscriber contribution, were not changed or amended as part of this filing. Therefore, the commenter's suggestion was not considered. Subsection 2699.400(f) was added in order to be in accordance with Chapter 701 Statutes of 2000, which amended Insurance Code Section 12698(c), to establish that a federally recognized California Indian Tribal Government can make required subscriber and infant contributions on behalf of a member of the tribe. The Legislature has not authorized any other form of formal sponsorship for the AIM Program.

Comment 1-G: The commenter states that subsection 2699.201(d)(1)(M)(1), on income verification, is confusing and should be clarified to identify what documents an individual must provide if he or she is verifying income with the previous calendar year option.

Response 1-G: Changes to Subsection 2699.201(d)(1)(M)(1) were made in order to note that there are other acceptable ways to document monthly gross household income for a previous calendar year and to provide alternatives for persons other than self employed, to submit tax and income related documentation for those that may not have filed a current year Federal Tax Return. Using the words, "either, otherwise, or and/or" help to clarify that there are other acceptable ways to document monthly gross household income besides submitting pay subs or federal tax form 1040, and therefore, we believe the proposed language provides the necessary clarity in identifying what documents are needed. We do not believe any further clarification is necessary.

Comment 1-H: AIM should adopt the Healthy Families and Medi-Cal rule allowing self-verification of income in certain limitations. AIM therefore,

should amend subsection 2699.201(d)(1)(M)(2)(a) to align with the HFP and Medi-Cal programs.

Response 1-H: In addition to pay stubs, unemployment stubs, and an employer letter, subsection 2699.201(d)(M)(2)(a) also notes that a self-employment profit and loss statement showing net profit for the most recent three month period of time from application date may also be submitted as income verification for the current calendar year. The three month profit and loss statement can be used in those cases where the applicant does not have pay stubs or is self employed. The use of the affidavit of income has only recently been incorporated into the Healthy Families Program regulations and was the result of recent legislation. There is currently no authority in State Statute (as with HFP and MC) to allow self-declarations of income for woman applying for the AIM Program.

Comment 1-I: Commenter recommends, referring to subsection 2699.201(d)(1)(P), that AIM drop its six-month durational residency requirement, noting that neither Healthy Families nor Medi-Cal has such a durational residency requirement.

Response 1-I: Subsection 2699.201(d)(1)(P) was amended in that the word "individual" was changed to "pregnant woman". The residency requirement was not amended. Since the residency requirement is in the enabling AIM statute, Section 12698, of the Insurance Code, a change of law would be required to consider such a change in the current eligibility requirements.

Comment 1-J: Commenter notes they support the proposed new regulation, subsection 2699.201(d)(3), which would require AIM to forward applications to Medi-Cal when the woman might be eligible for that program and has given her consent. In addition, the commenter recommends that the state have a single, simple form to use to apply for all Medi-Cal programs, Healthy Families, and AIM.

Response 1-J: It is the intent of the State to combine the HFP and AIM administrative vendors under one contract. When this new contract has been procured, there will be greater opportunity to align and coordinate the processing of applications for all three programs.

Comment 1-K: Healthy Families and Medi-Cal should forward applicable applications to AIM, and both the joint Medi-Cal/Healthy Families application and the separate Medi-Cal application should clearly inform women they will also be considered for AIM.

Response 1-K: This comment is not within the purview of the AIM Regulations. Moreover, this comment suggests changes to the Healthy Families and Medi-Cal programs. However, upon implementation of the HFP Parental Expansion, pregnant women applying for HFP will be referred to the AIM Program if they are determined to have income above 200% of the Federal Income Guidelines and to no-cost Medi-Cal if they are below 200% of the Federal Income Guidelines.

Comment 1-L: The commenter suggested that the Medi-Cal program change its requirements, in regards to subscribers reporting a change of address and/or phone number, from ten days to 30 days, to be in alignment with the requirements of the Healthy Families and AIM programs.

Response 1-L: This suggestion applies to the Medi-Cal program, which is managed by the Department of Health Services, and is not within the purview of the AIM Regulations.

Comment 1-M: AIM and Healthy Families should align with the Medi-Cal retroactive eligibility rule. At the very least, Healthy Families should adopt the AIM rule.

Response 1-M: The Healthy Families Program and the AIM Program are based on commercial insurance models. As such, they include cost sharing and prospective enrollment, whereas, Medi-Cal, is an entitlement program, and provides retrospective coverage. Subsection 2699.303 of the AIM regulations states that subscribers may be reimbursed up to a total of one hundred and twenty-five dollars for pregnancy-related, medically necessary services, received in the time period beginning forty calendar days prior to the application date that a complete application is received by the program and ending on the beginning date of coverage. Because the AIM Program encourages early prenatal care, the AIM Program design included this reimbursement feature, believing it would provide some financial assistance in payment of the pregnant woman's first prenatal visit, (e.g., request a pregnancy certification). The comment suggesting that the Healthy Families Program adopt this AIM reimbursement rule is not within the purview of the AIM Regulations.

Comment 1-N: Healthy Families should adopt AIM's approach on plan selection and benefits to assure access and continuity of services. Medi-Cal should adopt the Healthy Families and AIM approach on full-scope services for pregnant women.

Response 1-N: The commenter was agreeing wholeheartedly with the recent AIM procurement policy requiring that the participating health plans in AIM also participate in the Healthy Families Program to ensure continuity of services when an infant transitions from AIM to HFP. This policy is not governed under the AIM regulations although one of the reasons for aligning the benefits in AIM and HFP is to make this policy workable. However, the suggestion of requiring the HFP to provide the same approach on plan selection to assure continuity of care for pregnant women transitioning between Healthy Families and Medi-Cal is not within the purview of the AIM regulations.

Comment 1-O: MCHC Access contends that the Healthy Families Program (HFP) does not include coverage for psycho-social, nutritional and other Medi-Cal services that studies have shown significantly improve birth outcomes.

Response 1-O: This particular comment was not directed at the AIM Program and is not within the purview of these regulations.

COMMENTER 2: MRMIB – Eligibility, Enrollment, and Marketing Division

Comment: MRMIB staff recommended modifying subsection 2699.100(j), the definition of family member. The proposed revision was to provide clarity that the unborn child being counted as a family member is in reference to the unborn child of the pregnant woman for whom the application for AIM coverage has been filed and not the unborn child of anyone else living in the household. MRMIB stated the change was necessary to provide consistency between the AIM Program and the Medi-Cal for Pregnant Women Program, and to assure, that the unborn child, of the woman applying for benefits, is treated the same in the two programs. This change impacts the AIM application. The application will be updated at the next printing to reflect this change in definition and a draft of the change is included with the application (Item 15 in the Table of Contents).

Response: The proposed changes were incorporated. Providing this clarity assures there is consistency between the AIM Program and the Medi-Cal for Pregnant Women Program.

COMMENTER 3. MRMIB - Benefits and Quality Monitoring Division

Comment 3-A: MRMIB staff proposed that the duplicated sentences in subsection 2699.300(a)(3), on Medical Transportation Services, be removed.

Response 3-A: Subsection 2699.300(a)(3) was amended as suggested.

Comment 3-B: MRMIB staff proposed that subsection 2699.300(a)(4), on Emergency Health Care Services, be revised to be more consistent with Health and Safety Code section 1371.05 and with the benefits offered through the HFP.

Response 3-B: Subsection 2699.300(a)(4) was amended as suggested.

Comment 3-C: MRIMIB staff proposed that the prostrate cancer language on periodic health examinations for subscribers in subsection 2699.300(a)(5)(D) be removed because this screening is not applicable to females who are the only subscribers of the AIM program, or to infants.

Response 3-C: Subsection 2699.300(a)(5)(D) was amended as suggested.

Comment 3-D: MRIMIB staff proposed that the word “short-term” in subsection 2699.300(a)(14) be removed so that home health services and exclusions are more consistent with California Code of Regulations, title 28, section 1300.67(c).

Response 3-D: Subsection 2699.300(a)(14) was amended as suggested.

Comment 3-E: MRMIB staff proposed that subsection 2699.300(a)(19) on the hospice benefit be revised to be more consistent with Health and Safety Code section 1368.2 and with the benefits offered through the HFP. These allow for the hospice benefit to be available when life expectancy is 12 months or less.

Response 3-E: Subsection 2699.300(a)(19) was amended as suggested, to change the limit from 6 to 12 months.

Comment 3-F: MRMIB staff proposed that the exclusion for mental disorders that do not respond to generally accepted methods of treatment for mental disorders such as organic mental disorders with permanent brain dysfunction contained within subsection 2699.300(a)(21)(B) be removed to be consistent with the benefits offered through the HFP.

Response 3-F: Subsection 2699.300(a)(21)(B) was amended as suggested.

Comment 3-G: MRIMIB staff proposed that subsection 2699.301(a)(15), the acts of war exclusion, be revised to be more consistent with California Code of Regulations, Title 28, section 1300.67.05.

Response 3-G: Through the 15-Day Public Notice process, MRMIB amended the acts of war exclusion (subsection 2699.301(a)(15)) to be consistent with the Department of Managed Health Care's (DMHC) emergency regulations. The DMHC emergency regulation clarified that the acts of war exclusion only applied if the exclusion was approved by specific order of the DMHC director.

DMHC has now adopted final regulations that forbid the acts of war exclusion in its entirety for health plans it regulates, and no longer permits a specific order by the DMHC director to authorize the exclusion. Therefore, to further track the final DMHC regulations, MRMIB revised this subsection (during a third 15-Day Public Notice process) to remove the exclusion.

DATA, STUDIES, AND REPORTS RELIED UPON

MRMIB did not rely upon any specific reports. MRMIB relied upon experience in managing the AIM program, and applicable laws and regulations for Medi-Cal, AIM and HFP, and the Knox Keene Act and its implementing regulations.

STATEMENTS OF IMPACT AND MANDATE

a. The Managed Risk Medical Insurance Board has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs to which reimbursement is required by Part 7 (commencing with Section 175000) of Division 4 of the Government Code.

b. Statement of Alternatives Considered.

In accordance with Government Code Section 11346.5(a)(12), the Managed Risk Medical Insurance Board has determined that no alternative considered by the Board would be more effective in carrying out the purpose for which the regulations are proposed or would be as effective and less burdensome to affected private persons than the proposed regulations.

c. Statements of Impact on Local Agencies, Private Persons, Businesses and Small Businesses.

There are no non-discretionary costs or new costs to local agencies or school districts.

There is no impact on California housing costs.

The Board has considered the cost impact on representative private persons or businesses impacted by these regulations. The AIM Program currently provides health insurance for pregnant women and their child until age two. The changes to the program regulations align eligibility determination standards and procedures to be consistent with HFP and align benefits with Knox-Keene requirements. These changes will impact subscribers and applicants in the AIM program by improving program benefits and streamlining eligibility, but will not impact the premium rates charged subscribers.

d. Business Impact Assessment.

The Board has made an initial determination regarding the impact of these regulatory changes on California's businesses. There is no known significant statewide adverse economic impact directly affecting California businesses, including the ability of California businesses to compete with businesses in other states. The changes involve individuals who are applying for and receiving health coverage through AIM. This regulatory action will neither create new jobs or businesses nor eliminate existing jobs or businesses or affect the expansion of businesses currently doing business within California.

e. Fiscal Impact on State and Federal Government

The Access for Infants and Mothers (AIM) program serves pregnant women and their infants up to age two. Program funding consists primarily of Proposition 99 funds, along with Title XXI federal funds and state Tobacco Settlement funds. Program services costs are based on negotiated rates with contracted health plans. Health plans participating in AIM must be licensed by the California Department of Managed Care. As part of the licensing requirement, Health plans must provide health benefits that comply with the Knox-Keene Health Care Service Plan Act of 1975, including its amendments, and applicable regulations.

Most of the changes in these proposed AIM program improvement regulations reflect benefits that our contracted plans were already required to provide under current State licensing requirements. As part of the current contract solicitation process for AIM, interested health plans were provided copies of these draft regulation changes. To the extent that the clarification of benefit standards results in additional cost to the contracting plans, they have been built into the health plans proposed rates for the new contract period (July 1, 2002 through June 30, 2004). Furthermore, any additional cost resulting from improvements in the application and enrollment process have been included by our contracted administrative vendor (Care 1st Health Plan) in the recently completed negotiations for the current administrative contract that covers the period March

15, 2002 through December 31, 2003. These new health plan and administrative vendor rates, which may include some small increase resulting from these program regulations, were used to update AIM program costs in the May Revision of the 2002-03 budget. Total expenditures for the 2002-03 budget are $84 million, of which $75.9 million are State funds. These rates will also be used to develop AIM program cost for the 2003-04 budget. Infants born to AIM mothers with family incomes from 200% to 250% of the federal poverty level (FPL) are eligible up to age one for Title XXI federal funds under the State Children's Health Insurance Program (SCHIP). Costs for these infants are shared between the federal and state government using a 65%/35% ratio. As noted above, to the extent that these program regulations result in any increase in the health plan rates, their fiscal impact are included in the May Revision of the AIM program cost projection. Total federal dollars for the 2002-03 budget are $8.1 million.

SMALL BUSINESS IMPACT

These regulation changes will not impact small businesses. The regulation changes are necessary to make explicit that participating health plans are required to provide benefits consistent with the Knox-Keene Health Care Service Plan Act of 1975, including its amendments (Health and Safety Code Sections 1367-1374.16) and to align specific benefit descriptions with Knox-Keene requirements. In addition, the regulations also make AIM eligibility determination standards and procedures, and AIM benefit standards, more consistent with the standards in HFP. None of the impacted health plans are known to be small businesses.

AUTHORITIES AND REFERENCES

Authority: Sections 12696.5, Insurance Code

Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696, 12696.05, 12696.15, 12697.10, 12698, 12698.05, 12698.06, 12698.25, and 12698.30, Insurance Code.

DOCUMENTS INCORPORATED BY REFERENCE

No documents were incorporated by reference in these regulations: